

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011435

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 53

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10465

20465

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DATE AMENDED

INSTEAD OF

SHOULD READ.

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in 1b <u>16 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>543 Railroad Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>543 Railroad Ave.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alma Josephine Luna</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8th.</u> Year <u>1963</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1927</u>
9. AGE (last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (City and state or country) <u>Ozark County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William F. Tyson</u>		13b. MOTHER'S MAIDEN NAME <u>Elmyra Thomasspn</u>	
13c. NAME OF HUSBAND OR WIFE <u>P. Cornelius Luna</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>	
15. SOCIAL SECURITY NO. <u> </u>		16. INFORMANT <u>P.C. Luna, West Plains, Mo.</u>	
17. ADDRESS <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with Hemiplegia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>		20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>22-2-63</u> to <u>8 Mar 63</u> and last saw her alive on <u>5 Mar 63</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated:			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>West Plains, Mo.</u>	
22c. DATE SIGNED <u>12 Mar 63</u>		22d. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
22e. LOCATION (City, town, or county) <u>West Plains, Mo.</u>		(State) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3-11-63</u>	
24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-14-63</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Smith

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

D. H. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.